CHAPTER 4-000 NEBRASKA MEDICAL ASSISTANCE PROGRAM (NMAP): NMAP provides medical care and services to those who do not have sufficient income to meet their medical needs and who qualify according to the program definitions as aged, blind, or disabled.

4-001 Eligibility Categories

4-001.01 Individuals Eligible for Assistance Grant and Medical Assistance (MA): The following individuals are eligible for MA without a separate eligibility determination:

1. Individuals who receive a payment from AABD/MA or SDP/MA; and
2. Individuals who would receive a payment from AABD/MA if the SSI payment did not exceed the budgetary need.

{Effective 4/11/95}

4-001.02 Individuals Ineligible for Assistance Grant But Eligible for MA Only: Individuals who have income or resources in excess of the budgetary standards for AABD or SDP grants (see 469 NAC 3-000 ff.) are ineligible for an assistance grant.

{Effective 4/11/95}

4-001.02A Emergency Medical Services for Aliens: Aliens who are not lawfully admitted for permanent residence in the United States, or are not granted temporary resident status under P.L. 99-603 are eligible for medical assistance for payment of emergency medical services if the following conditions are met:

1. The alien has the sudden onset of a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) where the absence of immediate medical attention could reasonably be expected to result in -
   a. Serious jeopardy to the patient's health;
   b. Serious impairment to bodily functions; or
   c. Serious dysfunction of any bodily organ or part; and

2. The alien meets all eligibility requirements in 469 NAC 2-000 ff. except:

    a. Citizenship and alien status (see 469 NAC 2-002);
    b. Referral to SSA for determination of blindness or disability (see 469 NAC 2-007.03A). The SRT completes the review of blindness or disability (see 469 NAC 2-007.03B); or
    c. Referral to SSI for potential income (see 469 NAC 2-010.01B6c(1)).

The determination that the client has an emergency medical condition in accordance with the guideline in number 1 and the review of blindness or disability is the responsibility of the State Review Team (SRT). The worker must submit current medical information (Form DM-5 and/or a narrative report) and Form DM-12D to the SRT. The SRT uses Form DM-5R to report to the worker the determination of medical emergency and the date by which this must be reviewed.

4-001.02B Eligibility of Family Members: The Medicaid eligibility of each family member must be determined based on the family's total countable income. The family's income is compared to the appropriate income standard for a family of that size. The worker must determine the eligibility of:

1. Uninsured children at an income level no greater than 185% of the Federal Poverty Level;
2. Insured children at an income no greater than the appropriate Federal Poverty Level determined by the child's age;
3. Adults using income standards no greater than the applicable medical categorical eligibility standards established by federal or state law.

For further explanation and examples, see 469-000-305.

4-001.03 (Reserved)

4-001.04 Blind or Disabled Recipients Eligible for MA: A blind or disabled recipient who has earned income is eligible for MA without regard to share of cost if s/he meets the guidelines in 469 NAC 4-001.04A or 4-001.04B. If a blind or disabled person reaches the age of 65, SSA may continue 1619(b) eligibility.

4-001.04A Current and Former SSI Recipients: A blind or disabled recipient who has earned income is eligible for MA without share of cost if s/he:

1. Received MA in the month before the month in which this reference applies and continues to receive SSI (regular SSI payments or special SSI payments under section 1619(a) of the Social Security Act); or
2. Received MA and SSI in the month before the month in which this reference applies and whose SSI payment stopped due to the level of earnings and who is determined by SSA to have special Medicaid status under section 1619(b) of the Social Security Act. The 1619(b) status can be verified from the State Data Exchange (SDX6, Special Medicaid Status field).

It is not necessary to compute Form DA-3M.

If SSA reviews the client's disability and determines that s/he is no longer disabled, the case must be closed in the first month possible considering the ten-day notice requirement.

4-001.04B Former AABD State Supplemental Payment (SSP) Recipients: A blind or disabled recipient who has earned income is eligible for MA without excess income if s/he:

1. Received an AABD state supplemental payment and MA (but not SSI) in the month before the month in which this reference applies;
2. Except for earnings continues to meet all of the eligibility requirements for AABD and has unearned income less than the AABD standard of need;
3. Continues to be blind or have a disabling impairment as determined by the State Review Team (SRT);
4. Would be seriously inhibited from working without medical assistance; and
5. Has earned income in an amount insufficient to provide the same level of benefits available from SSP, MA, and Title XX attendant care. The income threshold used by SSA for purposes of determining eligibility for 1619(b) status will be used for this determination.

It is not necessary to compute Form DA-3M.

The continuing blindness/disability review in number 3 must be completed before the end of the 12th month after this section applies, and annually thereafter. See 469 NAC 2-007.03B1, "Forms Necessary," to make the referral to the SRT for this review. The worker should note on Form DM-12D the client's status under this section.

4-002 Cooperation in Obtaining Health Insurance: As a condition of eligibility for MA, a client is required to enroll in an available health plan if the Department has determined that it is cost effective and the client is able to enroll on his/her own behalf. The Department then pays the premiums, deductibles, coinsurance, and other cost sharing obligations.

4-003 Effective Date of Medical Eligibility: If an individual is eligible for medical assistance one day of the month, s/he is eligible the entire month. The effective date of eligibility for MA is determined as follows:

1. Prospective eligibility is effective the first day of the month of request if the client was eligible for MA in that same month and had a medical need.

Exception: For AABD/MA or SDP/MA blindness/disability cases, the date of prospective eligibility begins -

a. With the first month of entitlement for SSI or the month of onset of a disability which is established for RSDI (when this date is after the month of request); or
b. The first day of the month in which the State Review Team determines disability to exist, when this date is after the month of request.

Prospective periods of eligibility for AABD/MA disabled cases not covered by an SSI/RSDI disability decision may be submitted to the State Review Team for a disability decision (see 469 NAC 2-007.03B ff.). The person must have a medical need and meet other eligibility criteria.

2. Retroactive eligibility is no earlier than the first day of the third month before the month of request, if the following conditions are met:

   a. Eligibility is determined and a budget computed separately for each of the three months;
   b. A medical need exists; and
   c. Elements of eligibility are met for each month.

   An applicant may be eligible for the retroactive period (or any single month(s) of the retroactive period) even though ineligible for the prospective period.

   Retroactive periods of eligibility for AABD/MA blind/disabled cases not covered by an SSI/RSDI disability decision may be submitted to the State Review Team for a disability decision. The individual must have had a medical need and have met other eligibility criteria during those months.

If the client was not eligible for one or more months of the retroactive period, the case must contain documentation of the ineligibility.

4-003.01 Six Months' Continuous Eligibility: Children from birth through age 18 are eligible for six months of continuous Medicaid from the date of initial eligibility unless:

1. The child turns 19 within the 6 months;
2. The child moves out of state;
3. The worker determines that the original eligibility was based on erroneous or incomplete information;
4. The child dies; or
5. The child enters an ineligible living arrangement (see 477 NAC 2-008.01).

No income or resource review is required.

For budgeting after the six months' continuous Medicaid, see 477 NAC 1-010.01.

Note: Newborn children for whom Medicaid paid for the birth are eligible to age one year.

{Effective 6/28/11}

4-004 Use of Budget Form DA-3M: The worker uses Form DA-3M or N-FOCUS to determine eligibility for medical assistance only and medical assistance share of cost cases. If at any time factors change that affect the budget, the worker must recompute Form DA-3M or N-FOCUS.

If the parent(s)' income has been deemed to the child, the medical expenses (including insurance premiums) of the parent(s) and any siblings for whom the parent(s) is responsible for paying medical expenses may be applied to the child's share of cost.

4-004.01 Use of Budget Form DA-4M: The worker uses Form DA-4M or N-FOCUS for an eligible spouse in a specified living arrangement and an ineligible spouse in the community (see 469 NAC 4-007.01 ff.).

Side 2 of Form DA-4M is used to calculate the amount of income (if any) to be allocated from the eligible spouse to the ineligible spouse and/or family members.

Side 1 of Form DA-4M is used to calculate eligibility for medical assistance only or medical assistance with share of cost for the eligible spouse.

4-005 Treatment of Resources: For the treatment of resources, the criteria outlined in 469 NAC 2-009 are used. The application for an individual who has excess resources other than real property may be held pending until the resources are reduced. For the liquidation of real property, see 469 NAC 2-009.07B4. Excess resources may be reduced by paying obligations for medical costs. Medical eligibility begins with the first day of the month of the incurred obligation which was used to reduce the resources to the allowable maximum (see 469 NAC 2-009.11). Medical eligibility may not be established earlier than the three-month retroactive period.

4-005.01 Maximum Available Resource Levels: The established maximum for available resources which the client, or the client and responsible relative, may own and still be considered eligible for MA, according to unit size, are as follows:

1. One member unit - client only $4000
   If a couple has a valid designation of resources and -
   a. There is an eligible spouse and an ineligible spouse, the resource level for the eligible spouse is $4,000; or
   b. The ineligible spouse later becomes eligible, each spouse is allowed $4,000.

2. Two member unit - $6000
   a. Client and eligible spouse;
   b. Client and ineligible spouse; or
   c. Client and ineligible spouse who have designated resources but the client returns home or no longer is eligible for waiver services.

For procedures on designating resources, see 469 NAC 2-009.02C ff. For resource levels for grant, see 469 NAC 2-009.08.

If two or more related AABD/MA or SDP/MA clients (other than a married couple), i.e., an eligible AABD/MA parent and his/her eligible AABD/MA minor child or two or more unrelated eligible AABD/MA clients, reside in the same household, each client is entitled to a resource maximum of $4000.

The treatment of resources of a spouse or a parent is the same as for a client (see 469 NAC 4-005).

If the total equity value of available non-excluded resources exceeds the maximums specified above, the client(s) is ineligible. Resources must be below the maximum resource level for one day in the month in order for the client to be eligible for that month.

4-005.01A Deeming Resources of a Parent: In considering the resources of a parent(s) who is not considered an EP towards an eligible child age 17 or younger and living in the parent's household, the following resources are considered to the child whether or not they are actually made available:

1. All resources exceeding $4,000 in the case of one parent; or
2. All resources exceeding $6,000 in the case of -
   a. Two parents;
   b. One parent and spouse of the parent; or
   c. One parent and one minor sibling.
3. $25 each additional minor sibling in the parent(s)' household.

Resource exclusions listed in 469 NAC 2-009.02B apply to the parent's resources. The resources of the eligible child's brothers and sisters are not considered towards the child.

Note: If income of a parent is not deemed according to 469 NAC 2-010.01F1, resources are also not deemed.

4-005.02 Resource Review: The amount of total resources determines how often verification is required. Verification is completed on the following schedule:

One Person

Resource Total	Verification Frequency
$3,925 to $4,000	Monthly
$3,850 to $3,924.99	Quarterly
$3,500 to $3,849.99	Semi-Annually
$0.00 to $3,499.99	Annually

Two Persons

Resource Total	Verification Frequency
$5,850 to $6,000	Monthly
$5,700 to $5,849.99	Quarterly
$5,550 to $5,699.99	Semi-Annually
$0.00 to $5,549.99	Annually

If a worker has reason to believe that at any time there has been an increase in resources which may affect eligibility all resources must be verified immediately.

A resource review is not required for SSI recipients.

{Effective 6/18/2001}

4-006 Treatment of Income: For treatment of income, use criteria outlined in 469 NAC 2-010 ff.

4-006.01 Disregards for Medical Budgets

4-006.01A Medical Insurance Disregards: In addition to disregards outlined in 469 NAC 2-010.01E1, the cost of medical insurance premiums is deducted (including Medicare if the individual is responsible for paying it) (see 469 NAC 3-006.01C).

The cost of premiums for policies that are not considered health insurance are not allowed as a deduction for medical budgeting (see 469 NAC 2-010.01B2d).

4-006.01B Guardian or Conservator Fee: The expense of a guardian or conservator fee is allowed as paid, up to a maximum of $10 per month (see 469 NAC 3-004.03A7). If the guardian/conservator is required by the court to purchase a bond and file an annual report with the court, the amount allowed by the court for expenses (in excess of $120) may also be disregarded.

{Effective 6/18/2001}

4-006.02 For Client(s) in a Long Term Care Facility or Receiving Assisted Living Aged and Disabled Waiver Services: In addition to the maintenance allowance for long term care or the standard for Assisted Living, the following expenses are deducted:

1. Cost of homeownership up to six months (see 469 NAC 3-006.02B5);
2. Cost of rent expense up to six months (see 469 NAC 3-006.02B5); and
3. Guardian or conservator fee as paid, up to a maximum of $10 per month (see 469 NAC 3-004.03A7). If the guardian/conservator is required by the court to purchase a bond and file an annual report with the court, the amount allowed by the court for expenses (in excess of $120) may also be allowed as a special requirement.

{Effective 5/11/99}

4-006.03 Repayment of Medicaid Benefits Provided in Error: When an error has occurred in the amount of Medicaid benefits received by the client because of erroneously reported income or changes in income and/or private health insurance premiums (not Medicare), the worker shall send Form IM-64 requesting voluntary repayment in the following situations:

1. The client failed to report a change timely and the amount of benefits in error is $76 or more;
2. The client reported a change timely but the worker failed to take action in the first month possible and the amount of benefits in error is $251 or more; or
3. The client failed to report a change timely, the worker failed to take action in the first month possible, and the amount of benefits in error is $251 or more.

In determining if there was an error in Medicaid benefits and the period for which repayment should be requested, the worker shall keep in mind that the client is allowed ten days to report a change and must be given a ten-day notice of an adverse action. When repayment is requested, the worker should attempt voluntary restitution from the client effective with the first month that the worker should have correctly adjusted the budget.

Note: In cases of suspected fraud, the social service worker shall refer the case via Form ASD-63 to the Special Investigation Unit, Central Office, or in the Omaha Office, to the Omaha Special Investigation Unit. Once a case has been referred to the Special Investigation Unit, the worker shall take no action with regard to the prosecution of the suspected fraud except in accordance with instructions or approval by the Special Investigation Unit. However, the worker should complete normal case actions, including closing a case that is found to be ineligible and recovering benefits received in error.

4-006.03A Amount of Benefits in Error: The amount of benefits in error for a client who was grant/MA or MA only but should have been MA with a Share of Cost, or who was MA with a Share of Cost but who should have had a larger Share of Cost, is the smaller of -

1. The amount of Medicaid services received for that month; or
2. The amount of Share of Cost in error.

4-007 Standard Levels: The standard used to determine eligibility for medical assistance is determined by the unit or family size. When computing Form DA-3M, the following individuals are considered in determining the unit or family size:

1. Client; and
2. Spouse.

When computing side 1 of Form DA-4M, only the client is considered in determining the medically needy or Federal Poverty income level.

If the client is in a hospital (or receiving acute hospital care) or licensed alcohol/drug treatment center, the worker shall use the standard of need which most accurately reflects the client's living arrangement.

When computing a medical budget or side 1 of Form DA-4M, the worker uses the following steps to determine if the client is eligible for MA only or MA with excess:

1. Compare the client's net income to the percent of the Federal Poverty Level (FPL) (see 469-000-203). If the client's income is equal to or less than the FPL, the client is eligible for MA only. If the client's income is more than the FPL, go to step 2 to determine the amount of Share of Cost. For clients in long term care, go directly to step 2.
2. Subtract the medically needy income level from the client's net income to determine the amount of Share of Cost (see 469-000-203).

When a client enters long term care, the standard is not reduced to the long term care level or Assisted Living Waiver level until the first full month that the client resides in long term care.

4-007.01 Income When the Eligible Spouse Is in a Specified Living Arrangement and the Ineligible Spouse and/or Family Member(s) Is in the Community

4-007.01A Definitions

Community Spouse: A spouse who is -

1. Not applying for or receiving assistance;
2. Not residing with the alternate care spouse unless the alternate care spouse is in the home and eligible for Home and Community-Based Waiver Services; and
3. Not in a hospital, skilled nursing facility, intermediate care facility, or intermediate care facility for the mentally retarded.

Family Members: Minor children residing with a community spouse, or dependent parents or siblings of the community spouse or alternate care spouse who reside with the community spouse and could be claimed as dependents for tax purposes.

Maintenance Allowance: The amount deducted from an alternate care spouse's income to meet the maintenance needs of the community spouse and family members.

Maintenance Need Standard: The income standard to which the community spouse's and other family members' income is compared for the purpose of determining the amount of allowance which may be made from the alternate care spouse's income.

4-007.01B Allocation of Income: When computing the medical assistance budget for an alternate care spouse in a specified living arrangement, only his/her income (calculated on side 1 of Form DA-4M) is considered. Income of a community spouse is not considered available to the alternate care spouse. Some of the income of the alternate care spouse may be allocated to the community spouse and/or family members to bring their income up to a minimum monthly amount. The amount which may be allocated is computed on side 2 of Form DA-4M. If the community spouse does not provide verification of his/her income, Form DA-4M budget is not used. Form DA-3M budget would be used for the client and no allocation of the client's income would be made to the community spouse.

When allocated allowances are not made available to the community spouse, the worker shall not deduct these allowances from the client's income on side one of Form DA-4M. The worker shall deduct allowances for other family members even if the institutionalized spouse does not make these allowances available to the family members.

The alternate care spouse must be residing in one of the following living arrangements for these special budgeting procedures to apply:

1. A long term care facility;
2. An Adult Family Home;
3. A Licensed Assisted Living Facility;
4. A Center for the Developmentally Disabled; or
5. Receiving services in a Home and Community Based Service Waiver.

If the spouse no longer meets the definition of a community spouse, i.e., s/he enters a specified living arrangement, spousal impoverishment budgeting stops the first month possible considering adequate and timely notice.

These budgeting procedures apply beginning with the month an eligible spouse enters a specified living arrangement (even if it is a partial month) and cease with the first full month the alternate care spouse is no longer in a specified living arrangement. An assessment and designation of resources must be completed.

The community spouse or other family member(s) must not be on assistance if s/he is included in this budgeting procedure. They may be eligible for assistance in their own right, but may choose not to apply if this is to their benefit.

{Effective 5/8/05}

4-007.01C Determining Ownership of Income: The worker shall verify all income to determine the amount of the income and the individual in whose name the income is received. If payment is made in the name of both spouses, half is considered available to each spouse. The worker shall divide income by the number of payees if payment is made in the name of one or both spouses and a third party. Only the spouse's proportionate share is considered available to him/her. If income is paid to one spouse and a third party but the verification reveals that the income is intended for both spouses, the worker shall include both spouses in the division to determine the proportionate share.

If income does not specify either spouse, one-half of the amount is considered available to each spouse.

The client may appeal the assumption of ownership of income.

4-007.01D Determining the Family Member's Maintenance Need Standard: To determine each family member's need standard, the worker -

1. Takes the percent of the Federal Poverty Level (see 469-000-203);
2. Subtracts the family member's gross income; and
   Note: SSI is included as income.
3. Divides the result by 3.

The worker does a separate calculation for each family member. This is calculated on side 2 of Form DA-4M.

4-007.01E Determining the Spousal Maintenance Need Standard: To determine the community spouse's need standard, the worker -

1. Takes the percent of the Federal Poverty Level (see 469-000-203); and
2. Adds excess shelter costs, if any.

Excess shelter cost is the amount by which the rent or cost of home ownership (e.g. mortgage, taxes, insurance, cooperative/condominium maintenance fees) plus a utility standard exceed the prescribed shelter limit. The worker shall allow a utility standard even if utilities are included in the rent. The worker shall not prorate shelter costs even if someone lives with the community spouse. If the community spouse is paying board and room, the worker subtracts the food stamp allotment for one from the actual board and room paid to determine shelter. See 469-000-203 for the utility standard and the shelter limit. This is calculated on side 2 of Form DA-4M.

4-007.01F Determining the Maintenance Allowance: To determine the amount of income from the alternate care spouse that may be allocated to the community spouse and other family members, the worker -

1. Takes the family maintenance need standard;
2. Adds the spousal maintenance need standard; and
3. Subtracts the gross income of the community spouse. SSI is included. If the community spouse has self-employment income, the worker uses adjusted gross income (after deducting the cost of operation).

This is calculated on side 2 of Form DA-4M.

The spousal maintenance allowance must not exceed the maximum in 469-000-203. However, if a court has ordered the client to make support payments to the spouse in excess of the maximum, the court order takes precedence over the maximum.

The worker shall notify the couple on Form IM-8 of the actual amount of the maintenance allowance, if any, which is being deducted from the alternate care spouse's income.

The couple may appeal the maintenance allowance. To support an increase in the maintenance allowance, either spouse must establish that the community spouse needs income above the maintenance allowance because of exceptional circumstances resulting in significant financial duress. If the couple wins their appeal, the community spouse may reserve more than the maximum maintenance allowance.

4-007.01F1 Income Provisions: The worker includes all income in the calculation, including SSI and income of minors. If the primary income - RSDI, SSI, earnings, etc., - is equal to or exceeds the maintenance need standard, the worker does not need to verify other income. The worker does not need to verify income for anyone if it is $10 or less.

4-007.01G Budgeting the Alternate Care Spouse: The worker deducts the following amounts from the alternate care spouse's net earned and unearned income in computing the alternate care spouse's budget:

1. MNIL or FPL level (see 469 NAC 4-007, step 1 or step 2);
2. Guardian/Conservator fee;
3. Amount allocated to the community spouse and/or family member(s);
4. Medicare premium and/or health insurance premium. If the couple has a combined health insurance premium, the worker allows one-half of the amount on the client's budget.

This is calculated on side 1 of Form DA-4M.

For budget instructions see PAF 4-3.

4-007.02 Medical Budget Periods: The medical budget is normally computed for one month but may be computed for a period up to six months. See 469-000-301 for procedures.

4-008 Required Copayments: Effective April 1, 1994, AABD adults are required to pay a copayment for the medical services listed at 469-000-210. Copayment amounts are also listed at 469-000-210.

4-008.01 Covered Persons: With the exceptions listed at 469 NAC 4-008.02, AABD adults are subject to the copayment requirement.

The client's Medicaid card will indicate whether the client is subject to the copayment requirement. The provider may also verify the client's copayment status by contacting the Nebraska Medicaid Eligibility System (NMES).

4-008.02 Exempted Persons: The following individuals are exempted from the copayment requirement:

1. Individuals age 18 or younger;
2. Pregnant women through the immediate postpartum period (the immediate postpartum period begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends);
3. Any individual who is an inpatient in a hospital, long term care facility (NF or ICF/MR), or other medical institution if the individual is required, as a condition of receiving services in the institution, to spend all but a minimal amount of his/her income required for personal needs for medical care costs;
4. Individuals residing in alternate care, which is defined as Assisted Living facilities, centers for the developmentally disabled, adult family homes and Licensed Mental Health Centers;
5. Individuals who are receiving waiver services, provided under a 1915(c) waiver, such as the Community-Based Waiver for Adults with Mental Retardation or Related Conditions; the Home and Community-Based Model Waiver for Children with Mental Retardation and Their Families; or the Home and Community-Based Waiver for Aged Persons or Adults or Children with Disabilities;
6. Individuals with a Share of Cost (over the course of the a Share of Cost cycle, both before and after the obligation is met);
7. Individuals who receive assistance under SDP (program 07); and
8. Individuals who are subject to a monthly TMA or MIWD premium.

{Effective 2/14/09}

4-008.03 Covered Services: For covered and excluded services, see 469-000-210.

4-008.04 (Reserved)

4-008.05 Client Rights: If a client believes that a provider has charged the client incorrectly, the client must continue to pay the copayments charged by that provider until the Department determines whether the copayment amounts are correct.

If the client is unable to pay the required copayment, s/he may inform the provider of the inability to pay. While the provider shall not refuse to provide services to the client in this situation, the client is still liable for the copayment and the provider may attempt to collect it from the client.

The client has the right to appeal under 465 NAC 2-001.02.

4-008.06 Collection of Copayment: For provider procedures, see 471 NAC 3-008.04.

4-009 Nebraska Health Connection (NHC): Managed care is required for all active Medicaid-eligible individuals except those excluded groups listed at 469-000-308. For more information, see Title 482.